

1 **ARIZONA BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY**

2
3 In the Matter of:

No. 17A-DO-16-0134A-OST

4 Julie Lynch, D.O.
5 Holder of License No. 006758
6 For the practice of osteopathic medicine in
7 the State of Arizona

**FINDINGS OF FACT, CONCLUSIONS
OF LAW, AND ORDER
(Revocation)**

8
9 On July 6, 2017, this matter came before the Board of Osteopathic Examiners in
10 Medicine and Surgery for consideration of the Administrative Law Judge ("ALJ")
11 Thomas Shedden's proposed Findings of Fact, Conclusions of Law, and Recommended
12 Order. Julie Lynch, D.O., appeared before the Board; Assistant Attorney General
13 Jeanne Galvin represented the State; Assistant Attorney General Michael Raine,
14 provided independent legal advice to the Board.

15 The Board, having considered the ALJ's decision and the entire record in this
16 matter, hereby issues the following Findings of Fact, Conclusions of Law, and Order.

17 **FINDINGS OF FACT**

18 1. On March 1, 2017, the Arizona Board of Osteopathic Examiners in
19 Medicine and Surgery ("Board") issued a COMPLAINT AND NOTICE OF HEARING setting the
20 above-captioned matter for hearing on March 27, 2017, at the Office of Administrative
21 Hearings in Phoenix, Arizona.

22 2. Julie Lynch D.O. holds license number 006758 issued by the Board. Dr.
23 Lynch's license was summarily suspended by the Board through an Order dated
24 February 28, 2017.

25 3. The Board alleges that Dr. Lynch committed acts of unprofessional
26 conduct in violation of ARIZ. REV. STAT. sections 32-1854(9), (25), and (39). At the
27 hearing the Board withdrew its allegation that Dr. Lynch had also violated subsection
28 32-1184(18)

29 4. The matter was continued and the hearing was conducted on May 16,
30 2017.

1 5. The Board presented the testimony of Jenna Jones, its executive director.
2 Dr. Lynch testified on her own behalf and prepared a written statement that was
3 accepted into evidence.

4 6. On May 27, 2015, Dr. Lynch submitted to the Board an application for
5 licensure.

6 7. In her application Dr. Lynch responded "no" to the question asking if she
7 had been placed on probation or was the subject of any disciplinary action during her
8 residency or any internship.

9 8. While Dr. Lynch's application was pending, the Board received information
10 showing that Dr. Lynch had been placed on probation for academic reasons during her
11 postgraduate year two and that she was subsequently terminated from the program.
12 Through an email to the Board dated January 25, 2016, Dr. Lynch responded to the
13 Board's request for clarification stating that her answer was an oversight. Dr. Lynch
14 could not recall the specifics, but stated that she had a new-born at the time and that
15 she was juggling the competing demands on her time. She added that she was
16 discharged for a failure to wear her nametag.

17 9. On April 9, 2016, Dr. Lynch appeared at a Board meeting to address her
18 failure to disclose that she had been placed on probation.

19 10. The Board approved Dr. Lynch's application on April 9, 2016.

20 11. On July 1 2016, Ms. Jones received from Julie E. Antilla an email showing
21 that on April 15, 2016, Dr. Lynch had surrendered her Wisconsin DEA registration
22 number for cause and that Dr. Lynch had allegedly authorized two fraudulent
23 prescriptions for oxycodone and filled those prescriptions herself.

24 12. Ms. Antilla was processing Dr. Lynch's application for a DEA registration in
25 Arizona and wanted to call the issue to Ms. Jones's attention.

26 13. Dr. Lynch had not disclosed to the Board that there was a DEA
27 investigation related to her. Dr. Lynch's position is that the investigation was not
28 directed at her per se, but rather was related to someone fraudulently using her
29 prescription pad. In 2014, Dr. Lynch had reported to police in Wisconsin that there were
30 fraudulent prescriptions being written on her pads. Regarding the alleged fraudulent

1 prescriptions that Ms. Antilla reported, Dr. Lynch had not seen one of these scripts and
2 testified that it was not her signature on the other one.

3 14. The Board had entered into evidence investigative reports prepared by the
4 DEA and emails between Board staff and DEA staff.

5 15. The Board also had admitted into evidence an Investigative Report
6 prepared by investigator John O'Hair-Schattenberg. Mr. O'Hair-Schattenberg testified
7 about his investigation at a Board meeting on February 25, 2017; that testimony is
8 considered reliable.

9 16. Based on the information provided by the DEA, the Board opened an
10 investigation regarding Dr. Lynch.

11 17. Regarding the DEA investigation, in a letter dated July 21, 2016,¹ Dr.
12 Lynch informed the Board that: she had been approached by the DEA about
13 prescriptions that were allegedly written in a family member's name; she had explained
14 that she did not treat family members; she had not worked since December 2014;
15 because she did not have an active practice in Wisconsin and was moving to Arizona,
16 she willingly surrendered her DEA registration; no disciplinary actions were taken; and
17 the DEA agent told to her reapply in Arizona.

18 18. Based on its investigation, on December 14, 2016, the Board issued a
19 CONFIDENTIAL INTERIM ORDER FOR FITNESS FOR DUTY AND IMPAIRMENT EVALUATION
20 ("Interim Order"). In the Interim Order the Board found that Dr. Lynch had allegedly
21 written two fraudulent prescriptions for oxycodone to her mother and had picked these
22 up herself; that she had authorized a prescription for hydrocodone for her then
23 significant other; that she has Behcet's, a lesion on her brain and was taking
24 oxycodone.

25 19. The Interim Order also provided that Dr. Lynch had failed to update her
26 applicable addresses with the Board and that its attempts to contact her for additional
27 information had not been successful.

28 20. Through the Interim Order, the Board ordered Dr. Lynch undergo an
29 evaluation for possible addiction/impairment to be conducted by Michel Sucher, M.D. no
30

¹ Received by the Board on August 5, 2016.

1 later than December 27, 2016, and that she undergo a physical examination to
2 determine her Fitness for Duty no later than January 17, 2017.

3 21. As of the hearing date in this matter, Dr. Lynch had not complied with the
4 Interim Order and had not had either the physical examination or the substance abuse
5 evaluation.

6 22. In an email dated January 5, 2017, Dr. Lynch requested that she be
7 allowed to take a physical exam and urine drug screen rather than the evaluation
8 required by the Interim Order or, in the alternative, that there be a meeting or hearing on
9 the matter. Dr. Lynch explained that what the Board was requesting would cost \$2200,
10 that she could not afford the required testing, and that she did not understand why she
11 was being asked to undergo the required testing.

12 23. Dr. Lynch also wrote that the "short story is": I was diagnosed with
13 [redacted in original]; I had to leave work in 2014; I had applied for military disability and
14 hadn't worked for two years until August 2016; after a long recovery, it was decided that
15 the climate in Arizona would be better for my disease; and I have been working since
16 September seeing patients.

17 24. The Board set Dr. Lynch's matter for an Investigative Hearing before the
18 Board at its meeting on February 25, 2017. The Board's Exhibit 10 is the INVESTIGATIVE
19 HEARING NOTICE, which sets out the statutes under consideration as possible violations.

20 25. The Board does not set each Investigative Hearing for an individual time,
21 but rather takes the matters in the order presented on the agenda. Dr. Lynch was not
22 present when the Board called her matter and the Board voted to refer the matter for a
23 hearing at the Office of Administrative Hearings based on her failure to disclose and her
24 failure to undergo the examination and evaluation.

25 26. Dr. Lynch arrived at the Board meeting later in the day, and the Board
26 agreed to consider her matter at that time.

27 27. The Board had admitted into evidence a transcript of the Investigative
28 Hearing.

29 28. Ms. Jones described the Board's Investigative Hearing as memorable in
30 that she believed Dr. Lynch was talking over people and interrupting people, and that

1 some might even say she was belligerent; in her twenty-five years working for and on
2 boards, Ms. Jones had never seen a hearing like this one.

3 29. During the Investigative Hearing, the Board went into executive session.
4 When it returned to the public session, a Board member moved to summarily suspend
5 Dr. Lynch's license based on Dr. Lynch's conduct, demeanor and attitude, and the
6 manner in which she was answering the Board's question. The motion passed and, on
7 February 28, 2017, the Board issued INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW,
8 AND ORDER FOR SUMMARY SUSPENSION OF LICENSE ("Order for Summary Suspension").

9 30. The Board, through the Order for Summary Suspension and the Complaint
10 and Notice of Hearing, alleges that the DEA investigation demonstrated that Dr. Lynch
11 had written two fraudulent prescriptions for oxycodone to her mother. The Board has not
12 proven this allegation by a preponderance of the evidence. There was no substantial
13 evidence adduced to prove this allegation.

14 31. The Board, through the Order for Summary Suspension and the Complaint
15 and Notice of Hearing, alleges that during the DEA investigation it was discovered that
16 Dr. Lynch had authorized a prescription for hydrocodone/acetaminophen for her
17 significant other. The Board has not proven this allegation by a preponderance of the
18 evidence.

19 32. In her application Dr. Lynch responded "no" to the question asking if she
20 had been diagnosed with or developed initial or worsening conditions that did or may
21 impair her ability to safely practice medicine.

22 33. The Board, through the Order for Summary Suspension and the Complaint
23 and Notice of Hearing, alleges that Dr. Lynch had failed to disclose to the Board her
24 medical condition both in her initial application and at the April 9, 2016 Board meeting,
25 that she had memory problems, and that she was taking oxycodone. The Board has
26 proven this allegation by a preponderance of the evidence.

27 34. Dr. Lynch testified that she did not know that Behcet's syndrome was
28 required to be disclosed and she compared it to hypertension or high blood pressure. At
29 a Board Investigative Hearing however, Dr. Lynch disclosed that she previously had
30 gone (at least partially) blind. At the hearing in this matter, Dr. Lynch stated that it was

1 possibly due to her disease, but there was not enough known about Behcet's to be
2 certain.

3 35. Dr. Lynch acknowledged that she was taking oxycodone and was on a lot
4 of medication, but she testified that she has not had any since July 2016; she had
5 stopped working due to pain, not her health conditions.

6 36. Regardless of whether Dr. Lynch was required to disclose in her
7 application that she had Behcet's, she was required to disclose that she had gone blind
8 and that she was taking oxycodone for pain, both of which could impair her ability to
9 safely practice.

10 37. In section 7 of the application, Practice Experience, which asks for a list of
11 all facilities at which you have "practiced medicine, consulted medicine or had staff
12 privileges," Dr. Lynch wrote that she was presently self-employed at Alternative
13 Healthcare Family Practice Center in Delavan, Wisconsin.

14 38. The Board, through the Order for Summary Suspension and the Complaint
15 and Notice of Hearing, alleges that Dr. Lynch made a misrepresentation on her
16 application when she indicated that she "was working at the time of her application."

17 39. Dr. Lynch testified to the effect that when she submitted her application
18 she was torn between "yes" and "no" regarding whether she was practicing because her
19 business was still open. December 1 was her last day of work in 2014, but she still was
20 the owner of a business and was receiving orders for vitamins. It was not until just
21 before she moved to Arizona that she filed the articles of dissolution. She had not
22 worked in the sense that she had not been to her office since December 2014.

23 40. Standing alone, Dr. Lynch's explanation is not unreasonable. But
24 considering that she was not practicing because of her pain that required her to take
25 oxycodone, Dr. Lynch should have provided the Board with a more complete
26 explanation of her employment status when she filed her application.²

27 41. The Board, through the Order for Summary Suspension and the Complaint
28 and Notice of Hearing, alleges that Dr. Lynch failed to disclose at the April 9, 2016
29 Board meeting that the DEA was conducting an investigation related to her DEA

30 ² Presumably the Board's staff would have provided Dr. Lynch with direction as to how best to answer the
question considering her circumstances, but apparently she did not request help.

1 registration and that she did not report to the Board that she had later surrendered that
2 registration.

3 42. Dr. Lynch asserts that she was not obligated to disclose this information
4 because she was not informed that she was the target of the DEA investigation.³ Dr.
5 Lynch testified that the agent told her that if she voluntarily surrendered her DEA
6 registration that would be the end of it and that she should reapply in Arizona.⁴

7 43. Considering the severity of the issue (alleged fraudulent prescriptions for
8 oxycodone), Dr. Lynch should have disclosed the DEA investigation regardless of
9 whether she was the target.⁵ Similarly, Dr. Lynch should have disclosed that she
10 surrendered her Wisconsin DEA registration.

11 44. The Board, through the Order for Summary Suspension and the Complaint
12 and Notice of Hearing, alleges that Dr. Lynch failed comply with the Interim Order. The
13 Board has proven this allegation by the preponderance of the evidence. The
14 preponderance of the evidence also shows that the Board's reasons for ordering Dr.
15 Lynch to undergo the physical examination and substance abuse evaluation were valid.
16 In mitigation, Dr. Lynch had contacted Dr. Sucher regarding the required evaluation,
17 and she had contacted the Board (albeit late) to try and arrange less costly alternatives
18 than what was required by the Interim Order or, in the alternative, to have the matter set
19 for a hearing.

20 45. The Board, through the Order for Summary Suspension and the Complaint
21 and Notice of Hearing, alleges that during the Investigative Hearing Dr. Lynch's:

22 [C]onduct, demeanor, appearance and actions ... were disruptive, concerning
23 and unusual. She arrived with a very large Great Dane dog and explained that
24 the dog was her therapy dog as a result of her service in the Gulf War. She
25

26 ³ The Board argues that she must have known that she was being investigated, but the portion of the
27 DEA report it cited shows only that the DEA told Dr. Lynch that it was conducting an investigation, not that
28 she was the target.

29 ⁴ As set out in a footnote above, the DEA report has a redaction where the agent is describing the
30 circumstances of Dr. Lynch's surrender.

⁵ Although it appears that the DEA investigation had not begun when Dr. Lynch submitted her application,
it was on-going when she appeared before the Board in April 2016, which was before her license was
issued.

1 stated that she had difficulty hearing from the shots she encountered during the
2 Gulf War. She claimed that the dog served with her in Afghanistan.

3 [Her] appearance was disheveled and she had trouble speaking clearly. Her
4 words were slurred. In addition, she was argumentative with the Board members
5 and consistently conducted herself in an unprofessional manner. She continually
6 interrupted the Board with inappropriate statements, raised her voice and could
7 not compose herself. The Board members expressed concern with [her] behavior
8 and believed her to pose a threat to the public.

9 46. At the hearing in this matter, Dr. Lynch testified that she has a speech
10 impediment and dry mouth do to salivary gland removal, and that shortly before the
11 Investigative Hearing she had several teeth capped, which is why the Board may have
12 found her to be speaking unclearly during the Investigative Hearing.

13 47. At the hearing in this matter, regarding her behavior at the Investigative
14 Hearing, Dr. Lynch acknowledged that she was "a little put off and may have gone on a
15 soap box" because she was reprimanded to make her service dog sit, whereas the
16 service dog was standing in place as expected. She is of the belief that this reprimand
17 was wrong under the ADA.

18 48. Dr. Lynch also testified to the effect that she did become (further) upset at
19 the Investigative Hearing when a Board member "kept telling her" to look at the papers
20 in front of her.⁶

21 49. Dr. Lynch acknowledged that her service dog had not served in the Gulf
22 War with her (although she did so serve). But it appears that this statement was a
23 reaction based on what Dr. Lynch felt was improper treatment of her service dog.

24 50. Regarding her appearance and clothes, in addition to the allegation that
25 she was disheveled at the Investigative Hearing, Ms. Jones was critical of Dr. Lynch
26 because she wore a sleeveless top. Dr. Lynch did not understand what was wrong with
27 her manner of dress, but she testified to the effect that she had been living in hotels,
28

29
30 ⁶ A review of the Investigative Hearing transcript shows that the Board member's repeated instruction that
Dr. Lynch look at the papers in front of her, could be construed as badgering.

1 she wore the clothes she had available to wear, and that she was not bare-armed (as
2 she had on a shawl or sweater).

3 51. A review of the transcript from the Investigative Hearing shows that several
4 of the allegations in the Order for Summary Suspension and the Complaint and Notice
5 of Hearing are not true. For example, although Dr. Lynch stated that the service dog
6 served with her in the Gulf War, she did not state that it was as a result of that war that
7 she needed a service dog. She also never claimed that she (or the service dog) had
8 served in Afghanistan. Regarding her hearing loss, Dr. Lynch did tell the Board that she
9 was hard of hearing due to a gunshot, but not that the hearing loss was from shots
10 encountered during the War. Also, during the Investigative Hearing, Dr. Lynch informed
11 the Board that her dog was a service dog, not a therapy dog as the Board now alleges.

12 52. Ms. Jones's opinion is that if the Board had known about the DEA
13 investigation and Dr. Lynch's health conditions that it would not have granted her a
14 license in April 2016.

15 CONCLUSIONS OF LAW

16 1. The Board bears the burden of persuasion. ARIZ. REV. STAT. § 41-
17 1092.07(G)(2).

18 2. The party asserting a claim, right, or entitlement has the burden of proof,
19 and a party asserting an affirmative defense has the burden of establishing the affirmative
20 defense. The standard of proof on all issues in this matter is that of a preponderance of
21 the evidence. ARIZ. ADMIN. CODE § R2-19-119.

22 3. A preponderance of the evidence is:

23 The greater weight of the evidence, not necessarily established
24 by the greater number of witnesses testifying to a fact but by
25 evidence that has the most convincing force; superior
26 evidentiary weight that, though not sufficient to free the mind
27 wholly from all reasonable doubt, is still sufficient to incline a
28 fair and impartial mind to one side of the issue rather than the
29 other.

30 BLACK'S LAW DICTIONARY 1373 (10th ed. 2014).

4. Substantial evidence is evidence that a reasonable mind would use to
reach a conclusion. See *Mealey v. Arndt*, 206 Ariz. 218, 76 P.3d 892 (App. 2003).

1 5. The Board has authority to order a doctor to "undergo any combination of
2 medical, physical or mental examinations ... necessary to determine the physician's
3 competence." ARIZ. REV. STAT. § 32-1855(B).

4 6. The Board has authority to discipline a license holder for acts of
5 unprofessional conduct. ARIZ. REV. STAT. § 32-1855.

6 7. ARIZ. REV. STAT. section 32-1854 provides that:

7 For the purposes of this chapter, "unprofessional conduct"
8 includes the following acts, whether occurring in this state or
9 elsewhere:

10 ***

11 9. Procuring, renewing or attempting to procure or renew a
12 license to practice osteopathic medicine by fraud or
13 misrepresentation.

14 ***

15 25. Violating a formal order, probation or a stipulation issued
16 by the board under this chapter.

17 ***

18 39. Any conduct or practice that impairs the licensee's ability
19 to safely and skillfully practice medicine or that may
20 reasonably be expected to do so.

21 8. By failing to disclose in her application that she had become blind and that
22 she was using oxycodone for pain, Dr. Lynch made a misrepresentation by omission
23 and has violated ARIZ. REV. STAT. section 32-1854(9). That Dr. Lynch was using
24 oxycodone is also unprofessional conduct under ARIZ. REV. STAT. section 32-1854(39).

25 9. Dr. Lynch's failure to disclose to the Board that there was a DEA
26 investigation related to her DEA registration is a misrepresentation by omission and has
27 violation of ARIZ. REV. STAT. section 32-1854(9).

28 10. Dr. Lynch has not complied with the Board's Interim Order, which is a
29 violation of ARIZ. REV. STAT. section 32-1854(25). Dr. Lynch however did try to make
30 alternative arrangements given her financial situation. Although these other
arrangements were not satisfactory to the Board, this is a factor in mitigation.

 11. Because Dr. Lynch has committed acts of unprofessional conduct, the
Board has authority to discipline her license. ARIZ. REV. STAT. § 32-1855.

 12. The Board requests that her license be revoked.

1 13. Dr. Lynch's failure to disclose in her application that she had been blind
2 and that she was taking oxycodone for pain, and her failure to disclose the DEA
3 investigation during the April 2016 Board meeting are egregious. In addition, her
4 previous failure to disclose that she had been subject to probation and her failure to
5 inform the Board when she surrendered her DEA registration are factors in aggravation.

6 14. Considering all the facts and circumstances of this matter, Dr. Lynch's
7 license should be revoked.

8 **ORDER**

9 **IT IS ORDERED** that Julie Lynch D.O.'s license number 006758 is revoked.

10 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

11 Respondent is hereby notified that she has the right to petition for rehearing or
12 review. The petition for rehearing must be filed with the Board's Executive Director
13 within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition
14 for rehearing or review must set forth legally sufficient reasons for granting a rehearing
15 or review. A.A.C. R4-22-108. Service of this Order is effective five (5) days after the
16 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,
17 the Board's Order becomes effective thirty-five (35) days after it is mailed to
18 Respondent.

19 Respondent is further notified that the filing of a petition for rehearing or review is
20 required to preserve any rights of appeal to the superior court.

21 Done this day, July 11, 2017



THE ARIZONA BOARD OF
OSTEOPATHIC EXAMINERS

/s/ Jenna Jones
Jenna Jones
Executive Director

//

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1 ORIGINAL of the foregoing filed
2 this 11th day of July, 2017, with:

3 Arizona Board of Osteopathic Examiners
4 9535 E. Doubletree Ranch Rd.
5 Scottsdale, AZ 85258-5539

6 COPY of the foregoing filed
7 this 11th day of July, 2017, with:

8 Office of Administrative Hearings
9 1400 W. Washington St.
10 Phoenix, AZ 85007

11 COPY of the foregoing mailed/e-mailed
12 this 11th day of July, 2017, to:

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25 By: _____ J. Jones _____
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29
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